PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, October 24, 2000 at 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Floor 2, Boston, Massachusets. Present were: Dr. Howard K. Koh (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Mr. Albert Sherman (arrived late), Ms. Janet Slemenda, and Dr. Thomas Sterne. Dr. Clifford Askinazi and Mr. Benjamin Rubin absent. Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Mr. Paul Jacobsen, Deputy Commissioner, DPH; Ms. Nancy Ridley, Assistant Commissioner, and Ms. Marie Eileen O'Neil, Bureau of Health Quality Management; Dr. Deborah Klein-Walker, Associate Commissioner for Programs and Prevention, Ms. Lorelei Mucci, Research Analyst, Chronic Disease Surveillance Program, Bureau of Health Statistics, Research and Evaluation, Attorney Carl Rosenfield, Deputy General Counsel, Dr. Paul Dreyer, Director, Division of Health Care Quality, and Ms. Joyce James, Director, Determination of Need Program.

PERSONNEL ACTIONS:

In a memorandum dated October 10, 2000, Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of the reappointment of Robert McGovern, M.D. to the affiliate medical staff of Western Massachusetts Hospital, Westfield. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointment to the consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENT:	**RESPONSIBILITY:**	**MED. LICENSE NO.:**
Robert McGovern, M.D.	Internal Medicine/ Allergy/Immunology	37819

In a letter dated October 11, 2000, Katherine Domoto, M.D., Associated Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the provisional and consultant medical staff of

Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the provisional and consultant medical staff of Tewksbury Hospital be approved for a period of two years beginning October 1, 2000 to October 1, 2002:

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Chih Yeh, M.D.	Provisional/Affiliate Internal Medicine	80819

REAPPOINTMENT:	**STATUS/SPECIALTY:**	**MASS. LICENSE NO.:**
Herman Haimovici, M.D.	Consultant/Radiology	29566
David Berman, M.D.	Consultant/Urology	51207

In a letter dated October 2, 2000, Robert D. Wakefield, Jr., Executive Director, Lemuel Shattuck Hospital, recommended approval of the appointments and reappointments of physicians to the medical staff of Lemuel Shattuck Hospital, Jamaica Plain. Supporting documentation of the appointees' qualifications accompanied the recommendations. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the medical staff of Lemuel Shattuck Hospital be approved:

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Mark Bankoff, M.D.	Consultant/Radiology	37557
Daniel O'Leary, M.D.	Consultant/Radiology	32840

REAPPOINTMENTS:	**RESPONSIBILITY:**	**MED. LICENSE NO.:**
Anjali Andalkar, M.D.	Active/Pathology	49235
Gregory Clark, M.D.	Active/Psychiatry	47684

STAFF PRESENTATIONS:

"A REPORT ON IMPLEMENTATION OF NEW MANAGED CARE LAW (CHAPTER 141 OF THE ACTS OF 2000)":

Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management, said in part, "…On July 17th of this year a landmark law was passed in the Commonwealth. The actual title of that law is an Act Relative to the Managed Care Practice in the Insurance Industry. It's otherwise known as Patient Rights Healthcare Reform Law. This law was passed after many years of hard work…It was in July of this year that consensus was finally reached…This law was passed as a commitment to patient rights…There are a number of new patient protections that are afforded under the law. The first whereby enrollees may seek emergency care without prior approval from their health plan. This is probably the most notable of many of the new requirements. And it's one in which there has been a long history of concern by patients in terms of their right to be able to access emergency services. The second new patient protection allows for referrals to certain specialists for patients with certain illnesses or certain conditions without prior approval from a primary care physician. Standing referrals from a primary care provider to specialists are something that has also been long sought by consumers and patients. In certain cases there are actually provisions where no referrals are necessary in the area of obstetrical services, gynecological and pediatric, where more rights are accorded to individual patients…There are some new provisions…There is a prohibition on carriers for using financial incentives…it requires carriers to pay for health services that are medically necessary, consistent with generally accepted medical practices and covered under a health plan. This really helps to affirm the right of physicians to make clinical treatment determinations without interference by managed care organizations…When a provider leaves a plan, there are thirty-day periods of notice that must be given to patients. There's a thirty-day continuity at a minimum that must be provided to recipients of primary care services…The Office of Patient Protection has additional responsibilities including providing information to consumers. The Office of Patient Protection will be developing a web site…"

Mr. Kevin Beagan, Director of Health Policy Unit, Division of Insurance, said in part, "Prior to the announcement of this law, all HMOs and insured managed care plans were only subject to regulation by the Division of Insurance. With the enactment of this law, the Division of Insurance has a new Bureau called the Managed Care Bureau. The Department of Public Health has a new office referred to as the Office of Patient Protection, jointly responsible to regulate managed care. This law now gives physicians and patients greater control over decisions about medical treatment…It insures that medical decisions within managed care plans are going to be made by qualified physicians. It's going to require that payment for covered services deemed medically necessary be paid for by the managed care plans themselves. This law will establish more public oversight not only of HMO plans, but all insured managed care plans. As in the past, all managed care was regulated by the Division of Insurance, now all action will be subject to joint regulation by both the Department of Public Health and the Division of Insurance to ensure that plans are meeting the quality and the utilization review

standards…Prior to this, there was no provision in law for any decision to actually go outside of an HMO. Now it will be required that all providers and all consumers will have the right to go to that independent review panel…There will be an advisory committee established not only to oversee the work that the Division of Insurance and the Department of Public Health are doing regarding the implementation of rules for managed care oversight, but also to develop recommendations after evaluating the market regarding a system of universal health care in the Commonwealth of Massachusetts. All of these rules are established in order to assure that there are new regulations set up to make sure that all residents in Massachusetts are going to get health care services based upon the appropriateness of the services provided, and to make sure that the quality of care is provided at a level that meets the standards established by our agencies. In addition, there is a goal to insure that health care services not only meet quality and appropriateness standards, but likewise continue to be affordable, so that the individuals continue to be covered by insurance plans. In May 1998 Governor Cellucci had established by executive order what was possible to be established in order to monitor the managed care environment. One thing he had established was an Ombudsman that has been in place since July 1998 to assist consumers with the information about the managed care system and to guide consumers, through all their rights to appeal within the health care plan for any kind of denial or care that was not adequate provided by any managed care plan. This was established because there was no law authorizing the Governor to actually go any further. Now with the enactment of Chapter 141 in July of this year, it has allowed the establishment of many new mechanisms to make sure that managed care plans are doing things appropriately…A basis has been established to create a new interagency managed care oversight board chaired by the Secretary of the Executive Office of Health and Human Services; staffed by eight State agencies, including the Department of Public Health and the Division of Insurance. Those State agencies are responsible to oversee the work that is being done by the Department of Public Health and by the Division of Insurance to provide additional recommendations as the process evolves regarding new things that should be considered by the individual agencies…"

Mr. Beagan continued, "The major functions of the new Managed Care Office will be to accredit all managed care plans…Now with the implementation of this new law, whenever a managed care plan does want to operate in Massachusetts, they will be accredited only if they have quality assurance, utilization review systems, provider contracts and provider credentialing that meet minimal standards. We will need to make sure we review all those provider contracts on an annual basis. Likewise, we need to monitor to make sure that when consumers are informed of the benefits and rights, they are provided with adequate information by the managed care plan about how to access services, what types of services are available, which providers are available, and that they are notified when there are changes to the utilization review procedures We are also required to investigate any consumer complaints. If there are any instances where a health plan is not meeting the standards for utilization review or quality assurance, the provider or consumer as they contact the Division of Insurance will get an investigator that will look into the problem which may ultimately lead to fines or withdrawal of accreditation from a health plan. There are enforcement rights that are built into the law

to allow the Division of Insurance to take action when a health plan might not be operating according to the rules established for managed care.

The DOI regulations need to concentrate primarily on the accreditation standards that will be established for the managed care plans. The four major criteria the Division will concentrate on will be those standards which the plans must have in place for utilization review. Also for provider management and improvement, provider credentialing, and preventive health care. The Division's standards are required to be based upon national standards…As we set up those standards, any health plan will be required to submit accreditation materials annually that the Division will have to review to determine whether or not they meet the standards in order to get the accreditation status. If they are not able to get accredited by the Division of Insurance Managed Care Bureau, according to the law they will no longer be able to operate and offer health coverage in the Commonwealth. In addition, the Managed Care Bureau is required to establish contract provision standards to insure that all contracts that providers are entering into within the managed care plans include provisions that are protecting consumers. That the contracts do not include so called gag rule provisions that prevent a provider from actually discussing a course of treatment that may differ from what the managed care plan thinks is the appropriate treatment. Standards that identify the prompt payments that all providers will now be entitled to under the law, to get a response from the health plan forty-five days after submitting a completed claim. Or if the health plan does not respond within the required time frame, that the provider is entitled to interest over and above what the claim is worth. To make sure the contracts include continuity of care provisions so that the providers recognize even their responsibilities to continued care after they leave the network, in certain circumstances. And also to make sure that there are no incentives within the provider care plans that would tend to delay, limit or restrict access to health care. The last part of the DOI regulations is to concentrate on the consumer information and disclosure that will be required to provide to individuals , information not only about the benefits included within a plan, but also information about the quality data that is collected every year regarding provider disenrollment, regarding consumer's disenrollment from plans, so individuals can make more intelligent decisions about the plans as they go through their open enrollment rights every year…

Our DOI regulations are slated at this point to follow the same timeline as the Department of Public Health so that they are promulgated in December, and they also go though the emergency regulation process, and would finally be effective after a ninety-day period in March. The accreditation process is something that cannot happen overnight. Our agency becomes effective on January 1st. The regulations will be promulgated at the end of this year. We need to collect information from health plans and then complete the formal accreditation process. While most of the standards for utilization review and external grievance will be in place on January 1st, the process by which we complete the accreditation of all health plans will have to take place in the Spring and be completed by the middle of next year. We look forward to all of our ongoing meetings with the Department of Public Health. We are working closely as we can to make sure that it is a seamless process regarding the regulation of health care, and also to insure that as they systems are set up, there is a seamless way that consumers can

contact each of our agencies and get the help that they need, whether they are just inquiring about assistance about what their health plan has for an appeal process, or to complain so that we can make sure that the managed care system is working properly."

Senator Richard Moore of Worcester and Norfolk District, and Chair of House Committee, said, "…I think that with the passage of the legislation we have significantly addressed many of the concerns that the public has had relative to how managed care works and whether it works in the best interests of the patient, and strengthens the doctor/patient relationship. I think that was the main thrust of the legislation. And one of the main points that we included in it was to involve the Department of Public Health very aggressively in the oversight of managed care and the health insurance programs, because we want to emphasize the health side of that equation. It is really critical to making sure that we have quality health care delivered in a timely fashion to the people of Massachusetts. From my perspective, and I think the majority of the Legislature's perspective, we have addressed the issues that were presented in the petition for the ballot initiative on question five. My concern is that if the people are uninformed about that question and vote for it because it sounds wonderful, it sounds too good to be true and in fact is, it will cause tremendous disruption to our health services were it to pass. It will cost considerable money to the premium payers and to the taxpayers. I think we addressed the problem; we need to give this law and regulations that are forthcoming a chance to work, see whether we need any further adjustments to take care of the consumers' interest. But I think we have gone a long way toward that. Hopefully we have addressed it completely. Certainly in the course of the regulations we will do that. The question five goes too far, would be disruptive, and we hope that the people in their wisdom will dismiss as it should be at this case. It made its point, got action which certainly was delivered I think very effectively. It addresses the main points. I'm hopeful that we give this a chance. It's really critical that we move this process forward and give everybody their opportunities through the hearing process to have further input. If we find that there are areas that need further attention, we certainly can address that. But I think that this is an excellent step forward with the presentation today and the hearing, the regulations that will be forthcoming over the next several months, to get in place so that we will continue to have the best health care available in the nation. And tied to our progress that we are making on reducing the number of uninsured, and continue to work on that area. I think we can be very proud of what has been accomplished here."

"A PROFILE OF HEALTH AMONG MASSACHUSETTS WOMEN, 1998" – BY DEBORAH KLEIN WALKER, ASSOCIATE COMMISSIONER FOR PROGRAMS AND PREVENTION, AND LORELEI MUCCI, RESEARCH ANALYST, CHRONIC DISEASE SURVEILLANCE PROGRAM, BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION:

Ms. Lorelei Mucci, MPH, Research Analyst for Programs and Prevention said in part, "We are going to be focusing on health concerns among women…Breast cancer contributes substantial morbidity and mortality for Massachusetts women. It is the most common cancer among women, and the second leading cause for cancer mortality. And

at the national level, black women have continued to see increasing mortality related to breast cancer. Survival for breast cancer is greatly improved when tumors are detected at an early stage. Mammography is the most effective tool for the screening. Data has shown that mammography screening annually can reduce breast cancer deaths by twenty to thirty-nine percent in women fifty and older, and by seventeen percent among women forty to forty-nine…We have significant and substantial mammography screening among women in Massachusetts. We also see this in the U.S., but we can see that consistently in Massachusetts…We know that insurance is a barrier to getting medical care, in general, and in screening in particular. While there is still disparity in mammography screening among women, we have made great improvements in this state. We see that women in the lower income groups have lower rates of screening. Women with lower levels of education are not getting screening…We found that it was really the youngest women, only forty-six percent of Asian-American women who were age eighteen to thirty-nine had received a pap smear in the past three years. And this was the group that seems to have the greatest disparity among the pap smear. The youngest women, eighteen to twenty-four are not getting screening at the same rates as older women. And then also women sixty-five and older…And I think especially among women eighteen to twenty-four, this is the group that we might want to target in some stratification for screening. This is probably the age that many women are becoming sexually active. We have data by income, which is the women less than twenty-five thousand dollar household income are less likely to get a pap smear every three years. We see a similar pattern such as women in the lowest education group are less likely to get a pap smear screening…"

Ms. Mucci continued, "…Now we move on to the topic of family planning. Unplanned pregnancies have really poor health statistics for the mother and for the baby. Mothers with unplanned pregnancy are less likely to get prenatal care. They are more likely to smoke or consume alcohol. And then children of women of unplanned pregnancies are at greater risk of numerous things. Overall, seventy-two percent of women eighteen to twenty-four who are sexually active were using some form of birth control. We saw there was a small difference. That the young women were perhaps more likely to use birth control. We saw no difference with regard to race and ethnicity. We also saw very little difference by income or education. And the major method of birth control that women were using was the birth control pill. Nineteen percent of women were using condoms and then about twenty-seven percent were using some form of sterilization. In 1998 thirty-three percent of Massachusetts women eighteen to forty-four had said that they had been pregnant within the past five years. Among this group of women who had been pregnant within five years, we asked them, thinking back to your current or past pregnancy, just before you got pregnant, how did you feel about becoming pregnant? And these were the four responses that the women had. That they wanted to be pregnant then, which was fifty-four percent. They wanted to be pregnant sooner, fifteen percent, and that they wanted to be pregnant later, was twenty percent. And that they did not want to be pregnant at all, which is eleven percent…Among black women compared to white and Hispanic women, seventy percent of those women described their pregnancies as being unplanned. In relationship to income, it's really the women whose household income is less than thirty-five thousand dollars a year that said that their pregnancies were unplanned.

In 1998, six percent of Massachusetts women reported experiencing intimate partner abuse. And particularly notable, we saw really no difference with education, with income or race/ethnicity. Intimate partner abuse is a real health concern that cuts across all these demographic areas…Twenty percent of women who experienced intimate partner abuse in the past year described that on fourteen or more days they felt depressed, sad or blue, compared to six percent of those women who did not experience intimate partner abuse. Fifty-three percent said they had fourteen or more days in which they had poor sleep in the past month, compared to twenty-eight percent who had no experience of intimate partner abuse.

In summary, I think we can say that Massachusetts women are doing really well. We've seen significant changes in mammography, especially for black women and women who are uninsured. And we still see that there are disparities. In family planning, there has been a consistently high use of birth control…And finally, with regards to partner abuse, a hundred and nine thousand women were experiencing intimate partner abuse in Massachusetts every year. Women who are eighteen to twenty-four are at substantial risk. Women who experience this partner abuse are suffering consequences that are for themselves, their families and society as a whole."

Dr. Deborah Klein Walker, Associate Commissioner for Programs and Preventions said in part, "…This set of information really shows some real success that we have as a state. In terms of breast cancer, we were the first state to spend money on breast cancer screening. We've also received substantial funding from the Center for Disease Control to pay for pap smear screening…In terms of family planning and intimate partner violence, we also have a substantial program in the Department…We will be using this information to better target educational efforts…."

Chairman Koh, M.D., concluded, "…I think you can see the level of commitment that we have in the Department and state-wide about women's health issues. I'm very gratified to see those rising trends in mammography rates for the uninsured and for women of color. Similar trends for pap smears. The disparity for Asian-American women actually have been documented nationally. And I'm concerned that some of the low rates that we are seeing in Asian-American women have to do with cultural and language barriers. But that will have to be explored further. Family planning continues to be a very important women's health issue. And it is disturbing to see that one-third of pregnancies are unplanned. So that is a public health issue that needs more attention. The intimate partner violence issue is a theme for the month, since it's Domestic Violence Awareness month. The Governor has said, very well, that it used to be thought that intimate partner and domestic violence was a private matter that should be kept behind closed doors. In fact, this is a matter of public health. This is an issue we are trying to bring to the fore this month and beyond."

REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING MANDATORY TERMS AND CONDITIONS:

Ms. Joyce James, Director, Determination of Need Program, said, "The purpose of this memorandum is to request the Public Health Council's approval of final promulgation of the amendments to Determination of Need Regulations 105 CMR 100.000, Mandatory Terms and Conditions. The first amendment extends from January 1, 2000 to January 2, 2007, the authorization period of determinations for any convalescent, nursing and rest home projects, if made under M.G.L.c.111,s.25C and granted prior to June 1992, if the provider has filed a request for extension, pursuant to 105 CMR 100.756 and 105 CMR 100.551 (E1/2) prior to January 1, 2000. Six (6) BANYL (Beds Approved But Not Yet Licensed) projects will be affected by this amendment. As initially proposed, the amendment extended the determinations for the BANYL projects from January 1, 2000 to January 1, 2003. The second amendment extends from January 1, 2002 to January 1, 2007, the authorization period of determinations for any convalescent, nursing and rest home projects, if made under M.G.L. c.111, s.25C and granted after June 1992. Approximately 105 projects will be affected by this amendment."

After consideration, upon motion made and duly seconded, it was voted unanimously **to approve the Request for Final Promulgation of Amendments to Determination of Need Regulations 105CMR 100.000 Governing Mandatory Terms and Conditions**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,686**. A public hearing was held on September 15, 2000 at the Department of Public Health. Two of the three people who attended the hearing testified in support of the amendments. One speaker recommended that the expiration date for the 6 BANYL projects be extended from January 1, 2000 to January 1, 2007.

REQUEST APPROVAL FOR EMERGENCY PROMULGATION OF AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS (105 CMR 130.000) – NEEDLESTICK INJURY PREVENTION:

Ms. Marie Eileen O'Neil, Bureau of Health Quality Management presented the regulations. She said in part, "The purpose of this memorandum is to request the Public Health Council's approval for the promulgation of emergency amendments to the Department's hospital licensure regulations found at 105 CMR 130.000. The regulations set out requirements for hospitals aimed at reduction of needlestick and sharps injuries among health care workers. The regulations are required by and implement Chapter 252 of the Acts of 2000, An Act Relative To Needlestick Injury Prevention, which added a

new section 53D to Massachusetts General Laws Chapter 111. The new statute was signed into law on August 17, 2000 and becomes effective on or about November 15, 2000. The timeframes are so compressed that promulgation through the usual process involving notice and the holding of a public hearing prior to promulgation is impossible. Because both the statute and the proposed regulations are designed to protect the health and safety of health care workers in hospitals adoption of the proposed regulations on an emergency basis is warranted. The proposed regulations require hospitals to develop exposure control plans that include procedures for identifying sharps injury prevention technology; include sharps injury prevention technology as engineering or work practice controls; and require the maintaining of sharps injury logs for recording exposure incidents and use as a basis for continuing quality improvement. The regulations provide a process for excluding the use of sharps injury prevention technology in case where a demonstration can be made that there are circumstances where the technology does not promote employee or patient safety or interferes with a medical procedure. Finally, the Department, in consultation with the advisory committee, is required to compile and maintain a list of needleless systems, needles and sharps with engineered injury protections. Staff requests that the Council approve the promulgation of the proposed amendments as an emergency regulation."

After consideration, upon motion made and duly seconded, it was voted unanimously, **to approve the request for Emergency Promulgation of Amendments to Hospital Licensure Regulations (105 CMR 130.000) – Needlestick Injury Prevention**; that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,687**. Within the next ninety days, staff will hold a public hearing and solicit comments from interested parties and will return to request final promulgation of the amendments.

INFORMATIONAL BRIEFING ON PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING TRANSFER OF SITE PROCEDURES:

Ms. Joyce James, Director, Determination of Need Program said, "The purpose of this memorandum is to inform the Public Health Council of Staff's plans to hold a public hearing on the proposed amendment to the Determination of Need Regulation 105 CMR 100.720, Transfer of Site Procedures. The proposed amendment defines the population served by the facility with respect to the transfer of site of a project approved pursuant to 105 CMR 100.530 and not yet licensed or in operation, or a facility duly licensed. The amendment adds another review standard to increase service access in underserved areas and allows relocation of a long term care facility outside its service area. Under the current regulations, the population served by the facility is not defined by a circumscribed geographic area, making it difficult to accurately assess whether or not the transfer of site will serve a different population or the facility's existing population. The proposed amendment defines the population served by the facility as the population residing in the facility's primary service area, that is, the cities and towns that each account for five

percent or more of the facility's accummulatively ninety percent service –specific and age-specific annual inpatient discharges…The source of these discharges is the facility's patient origin data. This definition is based on the not surprising observations that the number of discharges to cities and towns from a facility tend to decrease with increasing distance from the facility and that a facility tends to serve primarily the cites and towns that are within easy travel distance to the facility. Access is an important factor in delivery and utilization of health care services. The absence in the current regulation of a defined service area for the population served, causes inconsistencies in implementation of the transfer of site procedures…Defining the service area of the population served will eliminate ambiguity in the interpretation of the regulations. The proposed definition of the service area may result in under served areas. Since services will be transferred only within the facility's primary service area, services might be clustered in certain geographic areas while other areas might go unserved. As a result of this, an additional review standard is being proposed. This standard will allow transfer of site outside a facility's primary service area, provided it can be demonstrated that the new site will significantly increase access to services by population of the new site's primary service area. A long term care facility is being allowed to relocate outside its service area. The current replacement of facilities at other sites within the service area and closure of the facilities in other service areas have resulted in excess capacity in some areas and insufficient capacity in others. However, the provider must demonstrate that access to services at the new site will be significantly improved. Staff will hold a public hearing on the proposed amendments and return to the Council as soon as possible with the proposed final regulations for Council's adoption."

INFORMATIONAL ONLY – NO VOTE

DETERMINATION OF NEED PROGRAM:

MEMORANDUM:

INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENTS TO DON EXPENDITURE MINIMUMS:

Ms. Joyce James, Director, Determination of Need Program, said, "The purpose of this memorandum is to request the Public Health Council's adoption of the Informational Bulletin of Annual Adjustments to the Determination of Need Expenditure Minimums. These adjustments are being requested in compliance with M.G.L. c.111, s.25B ½. Since the U.S. Department of Health and Human Services does not have an appropriate index, the inflation indices used by the DoN program staff to adjust DoN threshold dollar amounts are: Marshall & Swift – capital costs; DRI/McGraw Hill – operating costs. These indices have been chosen by the Determination of Need Program as an authoritative resource due to their extensive use within the health care industry to determine inflation rates for a number of healthcare expenditures. While each of the indices has various regional and market sector subtleties and shadings, it is important for ease of administration to use a single inflation factor for capital costs and a single factor for operating costs. Marshall & Swift's statewide figures are used for the capital cost

inflation and the average of DRI/McGraw-Hill hospital and nursing home figures is used as the basis for recalculating inflated operating costs. If usable figures are not available for September 1 of each year, inflation will necessarily be calculated as of some earlier date. These figures are effective September 1, 2000."

The meeting adjourned at 11:40 a.m.

_____

Howard K. Koh, M.D.
Chairman

LMH/sb